were observed, but they were clearly distinguishable by their larger size and by the absence of the zone of peripheral congestion.

Hospital Contagion of Pneumonia.—G. VARIOT (*Journal de Clinique et de Thérapeutique infantiles*, 1898, No. 13, p. 246) reports an apparently clear case of contagion.

Jean M. was admitted to the ward and placed in a bed beside that of Charles S., who was then just entering the acute stage of croupous pneumonia. Jean remained in the bed next to Charles during the whole course of the latter's disease, and eleven days after his admission, or six days after the defervescence of the disease in his neighbor, his temperature rose and he passed through an uneventful attack of the same malady.

This observation is by no means unique, similar cases having been recorded by Minot, Netter, and Comby. The author suggests that observations of this character, in which the dates are carefully noted, will enable one to determine the period of incubation of pneumonia. In such cases it is to be presumed that the transmission of germs has not been direct, but that the micro-organisms suspended in the dust or adhering to the bed-clothing have been the means of producing the disease. Netter, who has observed similar instances of contagion among adults, thinks that the direct transmission of germs should be rarer among young children, because they do not expectorate. It seems certain, however, that even if the child does not expectorate, like the adult, into a vessel, he coughs without any precaution, and in the paroxysms of cough must scatter minute portions of the pulmonary secretions upon his own or neighboring beds. It is also quite likely that during the course of the disease in Charles his neighbor came close to his bed.

SURGERY.

UNDER THE CHARGE OF

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Clinical Remarks on Stricture of the Urethra.—The following classification is one which HARRISON (*The Lancet*, April 23, 1898) uses for clinical purposes: First, those amenable to some form of dilatation; second, those found to be unadapted for such treatment, and where other measures should be considered; and third, those which may have been regarded as impassable strictures.

The first class includes by far the greatest number and all strictures in their early stages. When this process of treatment proceeds satisfactorily, as it usually does, the patient is soon able to undertake the management of his own case after he has been instructed in the use of the appropriate instrument. It is very easy to injure a stricture and so lose the way through it. On making an examination of this kind, the object should be to ascertain, without causing pain or bleeding, if possible (1) the presence and position of the obstruction, and (2) the degree of contraction which has been arrived at.

For this purpose the author prefers long, flexible bougies, twenty inches in length, which commence in a probe-point and gradually increase in size. They may be softened by placing them in warm water before use, and become so flexible that they will coil up in the bladder. Besides their use as exploratory instruments, he employs them to smooth out a rough urethra and make the access to a stricture funnel-shaped, so that it may be more easily entered. It is sometimes necessary to use filiform bougies to detect the entrance through the stricture. The long bougies ("whips") are useful in relieving retention of urine from a stricture that has contracted. The gradual dilatation produced persists sufficiently after the withdrawal of the instrument, so that the patient is able voluntarily to empty his bladder. They are very safe, as no force can be used with them, and the author believes they should be more generally employed.

The second class are cases that are not adapted to dilatation, as, for instance, those following wounds or injuries of the urethra. The difficulty may arise from the character of the scar tissue, its contractility, or there may be certain constitutional disturbances following attempts at dilatation of the gentlest kind.

These cases the author relieves by introducing a splice of new tissue into the floor of the stricture by internal urethrotomy, usually by Maisonneuve's instrument. As healing takes place under the occasional use of a bougie, a splice is formed of new tissue where the stricture was divided. For forty-eight hours or so before this is done it is well to sterilize the urine with some boric acid taken by the mouth, in small doses, or, as he has found better, boracite. The former sometimes produces indigestion, while the latter is both pleasant and reliable.

The filiform pilot is passed into the bladder, the fine metal director following it. The urethrotome is next run along the groove in the latter, and the strictures are divided from before backward. Care should be taken not to run the blade too far back and injure fibres of the sphincter, or excessive bleeding will be caused. A series of metal bulbous bougies (10–15, English gauge) should be passed successively before the patient recovers from the anæsthetic. All metal instruments for use in connection with a strictured urethra should be bulbous or olive-headed. The bladder is then emptied of any urine it may contain and washed out with a solution of perchloride of mercury (1 : 6000) until the lotion runs quite clear. An ounce or so is left behind in the bladder, so that the first urine voluntarily passed may be sterilized. Carbolized vaseline (three grains to two ounces) is used for the instruments. The author rarely ties a catheter in the bladder unless a chronic stricture has induced an atonic bladder, when a soft catheter may be